SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
Company Tracking Number:	*2009-AH-AR-FO-593*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Filing at a Glance

Company: OneBeacon America Insurance Company

Product Name: Accident & Health	SERFF Tr Num: BEAC-125909650	State: ArkansasLH
TOI: H02G Group Health - Accident Only	SERFF Status: Closed	State Tr Num: 41296
Sub-TOI: H02G.000 Health - Accident Only	Co Tr Num: 2009-AH-AR-FO-593	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Sharon Kennedy, Joshua Levine	Disposition Date: 01/13/2009
	Date Submitted: 01/09/2009	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Occupational Accident Travel Assistance Endorsement	Status of Filing in Domicile:
Project Number: 2009-AH-AR-FO-593	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Group
Submission Type: New Submission	Group Market Size: Small and Large
Overall Rate Impact:	Group Market Type: Employer
Filing Status Changed: 01/13/2009	
State Status Changed: 01/13/2009	Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We are submitting for your review & approval the enclosed Travel Assistance Endorsement which will apply to our previously approved Group Occupational Accident Program.

Form AH 208 OA CW 10 08 provides, under certain conditions, specified travel assistance benefits to a covered person, as defined in the endorsement, if he or she sustains an illness or injury or dies during a covered trip.

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
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TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Travel assistance benefits include the arrangement of and costs associated with:

Medical Evacuation
Assisted Return of a Covered Person
Return of Remains
Visits to Hospital
Return of Child
Return of Companion

Travel assistance benefits are subject to pre-authorization requirements and exclusions as specified in the endorsement and there is no additional charge for this endorsement.

We would like to make this endorsement available effective as of the date of your approval for policies written prior to, on or after such date.

Please contact me should you have any questions or require additional information.

Sincerely,

Sharon Kennedy
OneBeacon Insurance Company
(781) 332-8190

Company and Contact

Filing Contact Information

Sharon Kennedy, Compliance Analyst	skennedy@onebeacon.com	
One Beacon Lane	(781) 332-8190 [Phone]	
Canton, MA 02021-1030	(888) 209-7219[FAX]	

Filing Company Information

OneBeacon America Insurance Company	CoCode: 20621	State of Domicile: Massachusetts
One Beacon Lane	Group Code: 1129	Company Type:

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
Company Tracking Number:	*2009-AH-AR-FO-593*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Canton, MA 02021-1030
(781) 332-7000 ext. [Phone]

Group Name:
FEIN Number: 04-2475442

State ID Number:

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
Company Tracking Number:	*2009-AH-AR-FO-593*		
TOI:	*H02G Group Health - Accident Only*	*Sub-TOI:*	*H02G.000 Health - Accident Only*
Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$20.00
Retaliatory?	No
Fee Explanation:	AR fee for forms filed apart from the basic form =$20.00 per form, per company. 1 form x 1 company = $20.00.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
OneBeacon America Insurance Company	$20.00	01/09/2009	24927636

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
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Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/13/2009	01/13/2009

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
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Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Disposition

Disposition Date: 01/13/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
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Company Tracking Number:	*2009-AH-AR-FO-593*		
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Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement/Memorandum of Variability	Approved-Closed	Yes
Form	Travel Assistance Endorsement	Approved-Closed	Yes

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
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Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AH 208 OA CW 10 08	Certificate Amendment, Insert Page, Endorsement or Rider	Travel Assistance Endorsement	Initial		54	2008 CW Occupational Accident Travel Assistance Endorsement.pdf

Policyholder: [Name] Effective Date of Endorsement: [June 1, 2008]

Policy Number: [XXX-XXX-XXX]

TRAVEL ASSISTANCE ENDORSEMENT

Travel Assistance will be available to the following **Covered Persons** when they are traveling [100] miles or more from the **Insured Person's Principal Residence**: the **Insured Person** and his or her **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)**, if the **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** are with the **Insured Person** while he or she is covered under this **Policy**. The **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** will not be covered while making a trip without the **Insured Person**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500]. Under this **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

  Medical Evacuation
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with the appropriate medical care required for such **Injury** or **Illness**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is $[50,000.00].]

  Assisted Return of Covered Person
  If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the **Insured Person's Principal Residence**, in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel, if required, which are covered. [The maximum amount **We** will pay for this benefit is $[25,000.00].]

  Return of Remains
  If a **Covered Person** dies while on a **Covered Trip, We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500]. [The maximum amount **We** will pay for this benefit is $[5,000.00].]

Visit to Hospital
If a **Covered Person** is scheduled to be hospitalized for more than [seven (7)] consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, the transportation for the person chosen by the **Covered Person** to visit such **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500].] [The maximum amount **We** will pay for this benefit is $[5,000.00].]

Return of Child
If an **Insured Person** is **Injured** or **Ill** while traveling with his or her **Dependent Child(ren)** on a **Covered Trip**, causing such **Dependent Child(ren)** to be left unattended, **We** will arrange and pay for the transport of the **Dependent Child(ren)** and for an attendant, if applicable. They will be transported to the location chosen by the **Insured Person**. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500].] [The maximum amount **We** will pay for this benefit is $[5,000.00] per **Dependent Child** and $[5,000.00] per attendant.]

Return of Companion
If a **Covered Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person** such **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the companion's return. **We** must pre-authorize such costs for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500].] [The maximum amount **We** will pay for this benefit is $[5,000.00].]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VI General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from

   [the deliberate ingestion of a [poison,] [fume,] [noxious chemical substance][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][;][or] [a non-prescription drug, unless taken in accordance with its directions]. [This exclusion shall not apply to the ingestion of alcohol.];]

   [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions];
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with appropriate medical care required for such **Injury** or **Illness**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][;][.]
8. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A

report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.]

- **[TRAVEL ASSISTANCE LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  $[500,000]]

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of **Travel Assistance** only, the following definitions apply:

  Covered Trip means when a **Covered Person** is traveling more than 100 miles from the **Insured Person's Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

  Domestic Partner means a person with whom the **Insured Person** has a legally recognized relationship as a Domestic Partner, Civil Union Partner, Reciprocal Beneficiary, or a person who has registered in a state or local Domestic Partner registry with an **Insured Person**.

  Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

  Principal Residence means the legal domicile of the **Insured Person.**

  For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy,** the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  [Right of Recovery
  We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance.]**

  [Excess Coverage
  Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance.**]

  [Reservation of Rights
  We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.]

  [Exempted Countries
  This Travel Assistance Plan is not available in the following countries: [named countries]. **We** further reserve **Our** rights to modify this list upon [ten (10)] days notice to the **Policyholder.]**

  Scope
  [Covered transportation expenses will be limited to air and marine conveyance.]

  Illness, as covered under **Travel Assistance,** is solely covered under **Travel Assistance,** and in no way supercedes or modifies the other **Coverages** provided under this **Policy**. All other **Coverages** provided under this **Policy** are available only as a result of a **Covered Injury**.

  [To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693].]

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Michael Miller, President & CEO
OneBeacon America Insurance Company

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
Filing Company:	*OneBeacon America Insurance Company*	*State Tracking Number:*	*41296*
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Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*BEAC-125909650*	*State:*	*Arkansas*
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Product Name:	*Accident & Health*		
Project Name/Number:	*Occupational Accident Travel Assistance Endorsement/2009-AH-AR-FO-593*		

Supporting Document Schedules

		Review Status:	
Satisfied -Name:	Certification/Notice	Approved-Closed	01/13/2009

Comments:

Attachments:

Readability Certification.pdf

AR Certification.pdf

		Review Status:	
Bypassed -Name:	Application	Approved-Closed	01/13/2009
Bypass Reason:	Not applicable.		

Comments:

		Review Status:	
Satisfied -Name:	Statement/Memorandum of Variability	Approved-Closed	01/13/2009

Comments:

Attachments:

Statement of Variables Travel Assistance Endorsement.pdf

2008 CW Numbered Occupational Accident Travel Assistance Endorsement.pdf

READABILITY CERTIFICATION

This is to certify that the form(s) below has (have) been subject to the Flesch Reading Ease Test.

A. Option Selected

_____ 1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is _____.

__X__. 2. Policy and riders are scored separately for the Flesch reading ease test. Scores for the policy and each form are indicated below.

Form	Form #	Flesch Score
Travel Assistance Endorsement	AH 208 OA CW 10 08	54

B. Test Option Selected

__X__ 1. Test was applied to entire form(s).

_____ 2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of forms enclosed indicating word samples tested.

Company Name: OneBeacon America Insurance Company

Signature of Certifying Official: _____

Printed Name and Title of Certifying Official: Keith Firestone, Assistant Secretary

Certifying Official's Address: 1 Beacon Lane, Canton MA 02021-1030

Date Signed: January 7, 2009

RULE AND REGULATION 19 - CERTIFICATION

This is to certify that the enclosed endorsement complies with the provisions of Rule and Regulation19 as well as all applicable requirements of the Arkansas Insurance Department.

Signature

Keith Firestone, Assistant Secretary
Printed Name & Title

Date January 9, 2009

OneBeacon America Insurance Company
Form: AH 208 OA CW 10 08
Statement of Variables

General Comments:

* Brackets around conjunctions or punctuation will be included or deleted as needed in order to make the statement read correctly.

Introduction Paragraph

1. The range will be 0 to 250 miles.
2. The range will be $250 to $2,500.

Medical Evacuation

1. The range will be $250 to $2,500.
2. The range will be $25,000 to $100,000.
3. This will either be in or out.

Assisted Return of Covered Person

1. The range will be $250 to $2,000.
2. The range will be $10,000 to $50,000.
3. This will either be in or out.

Return of Remains

1. The range will be $250 to $750.
2. The range will be $2,500 to $10,000.
3. This will either be in or out.

Visit to Hospital

1. The range will be 3 to 30.
2. The range will be $250 to $750.
3. This will either be in or out.
4. The range will be $2,500 to $10,000.
5. This will either be in or out.

Return of Child

1. The range will be $250 to $750.
2. This will either be in or out.
3. The range will be $2,500 to $10,000.
4. The range will be $2,500 to $10,000.
5. This will either be in or out.

Return of Companion

1. The range will be $250 to $750.
2. This will either be in or out.
3. The range will be $2,500 to $10,000.
4. This will either be in or out.

Travel Assistance Exclusions

1. This will either be in or out.
2. This will either be in or out.

3. This will either be in or out.
4. This will either be in or out.
5. This will either be in or out.
6. This will either be in or out.
7. This will be in, if #8 is out.
8. This will be in, if #7 is out.
9. The range will be $250 to $2,500.
10. This will either be in or out.

Travel Assistance Limitations
Aggregate Limit of Liability per Covered Accident
1. The range will be $25,000 to $5,000,000.
2. This will either be in or out.

Travel Assistance Definitions
1. The range will be 0 to 250 miles.

Travel Assistance – Other Provisions
1. This will either be in or out.
2. This will either be in or out.
3. This will either be in or out.
4. Names of the countries deemed to be inaccessible based on world conditions.
5. The range will be 3 to 90.
6. This will either be in or out.
7. This will either be in or out.
8. The appropriate telephone number will be inserted.
9. The appropriate telephone number will be inserted.
10. This will either be in or out.

Policyholder: [Name] Effective Date of Endorsement: [June 1, 2008]

Policy Number: [XXX-XXX-XXX]

TRAVEL ASSISTANCE ENDORSEMENT

Travel Assistance will be available to the following **Covered Persons** when they are traveling [100][1] miles or more from the **Insured Person's Principal Residence**: the **Insured Person** and his or her **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)**, if the **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** are with the **Insured Person** while he or she is covered under this **Policy**. The **Spouse**/**Domestic Partner** and/or **Dependent Child(ren)** will not be covered while making a trip without the **Insured Person**. The transportation and/or services provided under **Travel Assistance** must be pre-authorized by **Us**. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][2]. Under this **Policy**, **Travel Assistance** consists of the following:

- **TRAVEL ASSISTANCE BENEFITS**

Medical Evacuation
If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and is being treated in a hospital, medical facility, clinic or by a medical provider which, based upon **Our** evaluation, cannot provide medical care in accordance with the appropriate medical care required for such **Injury** or **Illness**, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the nearest hospital or medical facility which can provide such care. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][1]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the standard of care of a hospital or medical facility, clinic or medical provider. [The maximum amount **We** will pay for this benefit is $[50,000.00][2].][3]

Assisted Return of Covered Person
If a **Covered Person** is **Injured** or **Ill** on a **Covered Trip** and has sufficiently recovered to travel with minimal risk to his or her health, **We** will arrange for, and cover the cost for, the transport of the **Covered Person** to the **Insured Person's Principal Residence**, in such transportation. **We** must be contacted prior to the transport and **We** must pre-authorize the transport for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][1]. No transport will be arranged for and/or covered without the prior recommendation of the attending **Physician**. For the limited purpose of determining **Our** liability, **We** have the sole right to determine the scheduling, the mode of transportation and the special equipment and/or personnel, if required, which are covered. [The maximum amount **We** will pay for this benefit is $[25,000.00][2].][3]

Return of Remains
If a **Covered Person** dies while on a **Covered Trip, We** will make arrangements and pay for the local preparation of the body for transport or cremation (not including the cost of cremation), travel clearances and authorizations, standard shipping container (not including urn or coffin) and transportation of the body or remains to its country of destination. **We** must be contacted prior to the preparation and transportation of the body and **We** must pre-authorize the services and transportation for benefits to be payable. However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][1]. [The maximum amount **We** will pay for this benefit is $[5,000.00][2].][3]

Visit to Hospital
If a **Covered Person** is scheduled to be hospitalized for more than [seven (7)][1] consecutive days while on a **Covered Trip, We** will arrange for, and cover the cost of, the transportation for the person chosen by the **Covered Person** to visit such **Covered Person** while he or she is hospitalized. We must pre-authorize the transportation for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][2].][3] [The maximum amount **We** will pay for this benefit is $[5,000.00][4].][5]

Return of Child
If an **Insured Person** is **Injured** or **Ill** while traveling with his or her **Dependent Child(ren)** on a **Covered Trip**, causing such **Dependent Child(ren)** to be left unattended, **We** will arrange and pay for the transport of the **Dependent Child(ren)** and for an attendant, if applicable. They will be transported to the location chosen by the **Insured Person**. **We** must pre-authorize the transportation of the **Dependent Child(ren)** and attendant, if applicable, for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][1].][2] [The maximum amount **We** will pay for this benefit is $[5,000.00][3] per **Dependent Child** and $[5,000.00][4] per attendant.][5]

Return of Companion
If a **Covered Person** is traveling with a companion while on a **Covered Trip,** and due to the **Illness** or **Injury** to the **Covered Person** such **Covered Person** cannot complete the **Covered Trip** as scheduled, **We** will pay for the companion's return. **We** must pre-authorize such costs for benefits to be payable. [However, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][1].][2] [The maximum amount **We** will pay for this benefit is $[5,000.00][3].][4]

- **TRAVEL ASSISTANCE EXCLUSIONS**

We will not provide **Travel Assistance** if the **Coverage** is excluded under Section VI General Exclusions of the **Policy**, or if:

1. the **Covered Trip** was undertaken for the specific purpose of securing medical treatment;
2. the **Injuries** or **Illness** requiring medical services resulted from

   [the deliberate ingestion of a [poison,][1] [fume,][2] [noxious chemical substance][3][;][or][the use of a prescription drug unless taken as prescribed by a **Physician**][4][;][or] [a non-prescription drug, unless taken in accordance with its directions][5]. [This exclusion shall not apply to the ingestion of alcohol.][6];][7]

   [the use of a controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 as amended and the regulations issued under its authority unless taken as prescribed by a **Physician** or for a non-prescription controlled substance unless taken in accordance with its directions][8];
3. with respect to a MEDICAL EVACUATION, the medical care, which is being provided, is consistent with appropriate medical care required for such **Injury** or **Illness**. **We** have sole discretion in making that determination;
4. with respect to MEDICAL EVACUATION, it is not medically necessary to transport the **Covered Person** to another hospital or medical facility. **We** have the sole discretion in making that determination;
5. based upon the medical condition of the **Covered Person** and/or the local conditions and circumstances, **We** determine that MEDICAL EVACUATION or ASSISTED REPATRIATION is not appropriate. **We** have sole discretion in making that determination;
6. any local, state, country or international law prohibits the provision of the transportation or services provided for under this plan. **We** will be fully and completely excused from performance and discharged from any contractual obligation;
7. **We** did not pre-authorize the transportation and/or services. However, for certain expenses, if it is not reasonably practicable for the **Covered Person** to contact **Us** for pre-authorization, the **Covered Person** may be reimbursed, at **Our** discretion, for appropriate covered expenses not to exceed $[500][9][;][.]
8. [the **Injuries** or **Illness** resulted in whole or in part from the **Insured Person** being intoxicated. An **Insured Person** will be conclusively presumed to be intoxicated if, on or about the time of the incident which required medical treatment, the level of alcohol in his or her blood exceeds the amount at which a person is presumed, under the law of the locale in which the **Accident** occurred, to be intoxicated, if operating a motor vehicle. A

report from a law enforcement officer, medical provider or any similar report will be considered proof of the **Insured Person's** intoxication.][10]

- **[TRAVEL ASSISTANCE LIMITATIONS**

  Aggregate Limit of Liability per Covered Accident
  $[500,000][1]][2]

- **TRAVEL ASSISTANCE DEFINITIONS**

  For purposes of **Travel Assistance** only, the following definitions apply:

  Covered Trip means when a **Covered Person** is traveling more than [100][1] miles from the **Insured Person's Principal Residence** and such travel is covered under the **Policy** and is not excluded under the TRAVEL ASSISTANCE EXCLUSIONS set forth above.

  Domestic Partner means a person with whom the **Insured Person** has a legally recognized relationship as a Domestic Partner, Civil Union Partner, Reciprocal Beneficiary, or a person who has registered in a state or local Domestic Partner registry with an **Insured Person**.

  Illness or **Ill** means a sickness or disease which impairs normal functions of the body.

  Principal Residence means the legal domicile of the **Insured Person.**

  For the purpose of **Travel Assistance**, if there are any differences in the definition of a term between **Travel Assistance** and the **Policy,** the definition in **Travel Assistance** will govern.

- **TRAVEL ASSISTANCE - OTHER PROVISIONS**

  [Right of Recovery
  We have the right to recover any benefits that **We** have paid under **Travel Assistance** if the **Policyholder** or **Insured Person** recovers any money from a third party for the expenses incurred by the **Policyholder** or **Insured Person** that were covered under **Travel Assistance. We** will be reimbursed from such recovery and **We** will have a lien against that recovery. **We** have the right to recover any benefits from the **Insured Person** for transportation services and/or expenses, which were not covered under **Travel Assistance**.][1]

  [Excess Coverage
  Our obligation to pay the **Policyholder** or **Insured Person** under **Travel Assistance** will be excess of any other insurance which the **Policyholder** or **Insured Person** has with respect to the expenses covered under **Travel Assistance**.][2]

  [Reservation of Rights
  We reserve the right to suspend, curtail or limit **Our** coverage in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strike, nuclear accident, act of God or refusal of authorities to permit **Us** to provide services or in any country for which a travel warning has been issued by the Department of State of the United States of America.][3]

  [Exempted Countries
  This Travel Assistance Plan is not available in the following countries: [named countries][4]. **We** further reserve **Our** rights to modify this list upon [ten (10)][5] days notice to the **Policyholder**.][6]

  Scope
  [Covered transportation expenses will be limited to air and marine conveyance.][7]

  Illness, as covered under **Travel Assistance,** is solely covered under **Travel Assistance,** and in no way supercedes or modifies the other **Coverages** provided under this **Policy**. All other **Coverages** provided under this **Policy** are available only as a result of a **Covered Injury**.

[To contact **Us** regarding **Travel Assistance**, the **Insured Person** must call [1-866-670-6693][8] from the U.S. or Canada; and collect from anywhere else in the world at [+1-973-630-6693][9].][10]

Except for the above, this Endorsement does not vary, alter, waive, or extend any of the terms of the **Policy** to which it is attached.

Endorsement No. _____

In Witness Whereof, We have caused this Endorsement to be executed and attested, and, if required by state law, this Endorsement shall not be valid unless countersigned by our authorized representative.

Dennis R. Smith, Secretary
OneBeacon America Insurance Company

Michael Miller, President & CEO
OneBeacon America Insurance Company